3 Federally Qualified Health Centers (FQHC) Guidelines

3.1 Introduction

3.1.1 General Policy

This section covers all Medicaid covered services provided by Federally Qualified Health Centers (FQHC) as deemed appropriate by the Department of Health and Welfare (DHW). Contents include the following:

- Encounters.
- EPSDT Services.
- Family Planning Services.
- Electronic and paper claim billing.
- Claims payment.
- Electronic and paper claim billing.

3.1.2 Advance Directives

An advance directive explains to a participant their right to accept or refuse medical services, or to choose among available medical services. It also explains Durable Power of Attorney and a Living Will.

Medicaid has directed that providers of home health care (including FQHCs, Rural Health Clinics and Indian Health Clinics) must provide all adult Medicaid participants advance directive information in an understandable format. If a participant is unable to read the information, a relative or friend reads the information to him/her. If no one else is available, the provider must read the advance directive information to the participant. If the provider is unable to abide by the medical desires of the participant, the provider is required to assist the participant in finding an alternative source of service.

3.1.3 Procedure Codes

Payment for medical screens is the all-inclusive rate for each participant encounter. Any service included in the definition of an encounter will be billed and reimbursed with one of the following encounter codes:

T1015 Physical or mental health visit

D2999 Dental health visit

Claims for ambulatory services will be paid according to Medicaid's rules, regulations, and limitations for the specific service being rendered (optometric, pharmacy, etc.)

Check eligibility to see if the participant is enrolled in Healthy Connections (HC), Idaho's primary care case management (PCCM) model of managed care. If a participant is enrolled, there are certain guidelines that must be followed to ensure reimbursement for providing Medicaid covered services. See *Section 1.5 Healthy Connections*, for the HC guidelines.

Participants who have passed the month of their twenty first birthday are eligible for an annual health risk assessment physical. Use diagnosis code **V70.0** when billing these adult assessments.

Note: Medicaid Basic Plan participants are eligible for up to 26 mental health services per year. Mental health encounters do not count toward the Medicaid Basic Plan participants 26 services per year limit.

3.1.4 Non-Covered Services

Federally Qualified Health Centers (FQHC) providers are advised to contact Medicaid prior to providing a new service to ensure they have met all criteria necessary to be qualified providers. Failure to notify Medicaid of a change in the ancillary services provided may result in the denial of a claim. Federally Qualified Health Centers encounters and ambulatory services, with the exception of home visits, must be provided on site.

The FQHC may obtain a separate physician clinic provider number to receive reimbursement for the physician hospital services at the rates on file with Medicaid. Physician services under contract to the

FQHC must be specifically identified in the contract with the FQHC. The contracted services must be applicable to all FQHC participants.

3.1.5 Third Party Recovery (TPR)

See *Section 2.4 Third Party Recovery*, for information on Medicaid policy for billing all other third party resources before submitting claims to Medicaid.

3.1.6 Tamper Resistant Prescription Requirements

To comply with federal regulations, Idaho Medicaid will only pay for outpatient drugs reimbursed on a fee-for-service basis when the prescription for the covered drug is tamper-resistant. If Medicaid pays for the drug on a fee-for-service basis, and the prescription cannot be faxed, phoned or electronically sent to the pharmacy, then providers must ensure that the prescription meets all three requirements for tamper-resistant paper.

Any written prescription presented to a pharmacy for a Medicaid participant must be written on a tamper-resistant prescription form that contains all of the following:

1. One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.
2. One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.
3. One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

Access to care:

The intent of this program is to reduce forged and altered prescriptions and to deter drug abuse. Emergency fills for prescriptions written on non-tamper resistant pads are permitted as long as the prescriber provides a verbal, faxed, electronic, or compliant written prescription within 72 hours after the date on which the prescription was filled. In an emergency situation, this allows a pharmacy to telephone a prescriber to obtain a verbal order for a prescription written on a non-compliant prescription pad. The pharmacy must document the call on the face of the written prescription.

3.2 Federally Qualified Health Center (FQHC) Policy

3.2.1 Overview

An FQHC is a community health center, a migrant health center, a provider of care for the homeless, an outpatient health program, or a facility operated by an Indian tribal organization under the Indian Self-determination Act. Some clinics that provide ambulatory services may qualify even though they are not receiving grants under *Section 329, 330*, or *340 of the Public Health Service Act*.

All services provided by an FQHC must be provided according to the rules and guidelines set forth by Medicaid for each type of service. Medicaid will not pay for services that are the responsibility of other providers (such as; participant care in a hospice, a nursing home or a hospital, etc.).

An FQHC may enter into the respective provider agreement observing all conditions applicable to all providers of the service after the Department of Health and Human Services and the Health Resources and Service Administration (HRSA) determine that the center meets the requirements to qualify for FQHC status.

3.2.2 Incidental Services

Services incidental to a billable encounter include:

- In-house radiology.
- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Audiology services.
- In-house laboratory services.
- In-house nutritional education or dietary counseling and monitoring by a registered dietician.
- Injectable medications.
- Medical equipment and supplies.

3.2.3 Encounters

An encounter is a face-to-face contact for the provision of medical, mental, or dental services between a participant and a physician, physician assistant, nurse practitioner, clinical nurse specialist, clinical psychologist, clinical social worker, dentist, or dental hygienist.

Types of encounters include medical, mental health, and dental.

Each contact with a separate discipline of health professional (medical, mental, or dental) on the same day at the same location is considered a separate encounter.

All contacts with all practitioners within a disciplinary category (medical, mental, or dental) in the same day is considered one encounter.

Reimbursement for services is limited to three separate encounters per participant per day, one for each discipline (medical, mental, or dental). An exception to this rule may be made if the encounter is caused by an illness or injury that occurs later the same day as the first encounter, requires additional diagnosis or treatment, and is supported by documentation.

3.2.3.1 Place of Service (POS)

Enter **50** FQHC code in the POS field on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.2.3.2 Child Wellness Exams

Child wellness encounters should be billed as a medical encounter using procedure code **T1015**. Report with diagnosis ICD-9 code **V20.1** or **V20.2** to show that the encounter is a well baby or child examination and to satisfy federal reporting requirements.

Complete information regarding child wellness exams is located in *Section 1.6 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), General Provider & Participant Information*. Sometimes child wellness exams are referred to as EPSDT screens.

3.2.3.3 Dental Encounter

An encounter is a face-to-face contact for the provision of dental services between a participant and a dentist or dental hygienist. The dental encounter code **D2999** should be billed with the diagnosis code **V72.2.** Dental services are limited for Medicaid participants.

Participants who are eligible for the Idaho Medicaid Basic Plan, including Pregnant Women under the PW Program, are covered under Idaho Smiles dental insurance as of September 1, 2007. Women in the PW Program have coverage only for those services that could harm either the mother or the baby. Contact Idaho Smiles Customer Service at: **(800) 936-0978** for assistance with billing questions for Idaho Medicaid Basic Plan participants.

Participants who are eligible for the Idaho Medicaid Enhanced Plan continue to be covered under Medicaid's Dental Program; there is no change in the process for submitting dental claims for Idaho Medicaid Enhanced Plan participants. For information about services that are considered a benefit of the Idaho Medicaid Dental Program, see *Section 3 Dental Guidelines.*

http://www.healthandwelfare.idaho.gov/portal/alias__Rainbow/lang__en-US/tabID__3438/DesktopDefault.aspx

Verifying eligibility for dental benefits:

- If the participant has an Idaho Smiles insurance card, verify eligibility through Idaho Smiles Customer Service at: **(800) 936-0978**, or online at: **www.bcidaho.com** (click on the Idaho Smiles logo).
- If the participant does not have an Idaho Smiles insurance card, use the participant's Medicaid identification (MID) number with the electronic point of service (POS) device, PES software, or Medicaid Automated Voice Response Service (MAVIS) at: **(208) 383-4310** or at: **(800) 685-3757)**, to determine eligibility. The eligibility response from MAVIS will be given in one of three ways:
  - Participant is eligible for Basic Plan (bill Idaho Smiles).
  - Participant is eligible for Pregnant Women (PW) Program (bill Idaho Smiles).
  - Participant is eligible for Medicaid (Enhanced Plan – bill EDS).

3.2.3.4 Other Ambulatory Services

If the FQHC wishes to provide other ambulatory services that are not part of the encounter, the provider must obtain a separate Idaho Medicaid provider number to receive payment for these services.

3.2.4 Laboratory Services

Laboratory tests performed by an FQHC are included in the encounter rate and cannot be billed to Medicaid. If an outside lab, not the clinic, performs a laboratory service, that lab must bill Medicaid directly.

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3.3 Family Planning Services

3.3.1 Overview

All claims for services or supplies that are provided as part of a family planning visit must include the **FP**, family planning modifier with encounter code **T1015**.

Family planning encounters should include one of the diagnoses listed in the table below as the primary diagnosis.

Diagnosis Code	Description
V25.01	Prescription of oral contraceptive.
V25.02	Initiation of other contraceptive measure (fitting of diaphragm, prescription of foams, creams, other agents.)
V25.09	Family planning advice (Other.)
V25.1	Insertion of intrauterine contraceptive device.
V25.2	Sterilization (admission.)
V25.40	Contraceptive surveillance, unspecified.
V25.41	Contraceptive pill surveillance.
V25.42	Intrauterine device (checking, reinsertion, or removal of device) surveillance.
V25.43	Implantable subdermal contraceptive surveillance.
V25.49	Surveillance of other contraceptive method.
V25.5	Insertion of implantable subdermal contraceptive.
V25.8	Other specified contraceptive management (post-vasectomy sperm count.)
V25.9	Unspecified contraceptive management.

3.4 Claim Billing

3.4.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

Note: All claims must be received within 12 months (365 days) of the date of service.

3.4.2 Electronic Claims

For PES software billing questions, consult the *Provider Electronic Solutions (PES) Handbook*. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software. See *Section 2.2.1 Electronic Claims Submission, General Billing Information*, for more information.

3.4.2.1 Guidelines for Electronic Claims

Provider Number: In compliance with HIPAA and the National Provider Identifier (NPI) initiative beginning May 24, 2008, federal law requires the submission of the NPI number on all electronic 837 transactions. Idaho Medicaid recommends providers obtain and register one NPI for each Medicaid provider number currently in use. It is recommended that providers continue to send both their Idaho Medicaid provider number and their NPI number in the electronic 837 transaction. Electronic 837 claims will not be denied if the transaction is submitted with both the NPI and the Idaho Medicaid provider number.

Detail lines: Idaho Medicaid allows up to 50 detail lines for electronic HIPAA 837 Professional transactions.

Referral number: A referral number is required on an electronic HIPAA 837 Professional transaction when a participant is referred by another provider. Use the referring provider's 9-digit Medicaid provider number, unless the participant is a HC participant. For HC participants, enter the provider's 9-digit HC referral number.

Prior authorization (PA) numbers: Idaho Medicaid allows more than one PA number on an electronic HIPAA 837 Professional transaction. A PA number can be entered at the header or at each detail of the transaction.

Modifiers: Up to four modifiers per detail are allowed on an electronic HIPAA 837 Professional transaction.

Diagnosis codes: Idaho Medicaid allows up to eight diagnosis codes on an electronic HIPAA 837 Professional transaction.

National Drug Code (NDC) information with HCPCS and CPT codes: A corresponding NDC is required on the claim detail when medications billed with HCPCS codes are submitted. See *Section 3.18.6.3* in the *Physicians Guidelines,* for more information.

Electronic crossovers: Idaho Medicaid allows providers to submit electronic crossover claims for Professional services.

3.4.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

Example: July 4, 2006 is entered as 07042006

3.4.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly in the appropriate field.
- Keep claim form clean; use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MMDDCCYY) format; note that in field **24A** (From and To Dates of Service) there are smaller spaces for entering the century and year; Refer to specific instructions for field **24A**.
- You can bill with a date span (From and To Dates of Service) **only if** the service was provided every consecutive day within the span.
- A maximum of six line items per claim can be accepted; if the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements; total each claim separately.
- Be sure to sign the form in the correct field; claims will be returned that are not signed unless EDS has a signature on file.
- Do not use staples or paperclips for attachments; stack the attachments behind the claim.
- Do not fold the claim form(s); mail flat in a large envelope (recommend 9 x 12).
- Only one PA number is allowed for paper claims.
- When billing medications with HCPCS/CPT codes, an NDC Detail Attachment must be filled out and sent with the claim.

3.4.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
PO Box 23
Boise, ID 83707

3.4.3.3 Completing Specific Fields of CMS-1500

Consult the, Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid Program are shown on the following table. There is no need to complete any other fields. Claim processing will be interrupted when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form.

Note: Claim information should not be entered in the shaded areas of each detail unless specific instructions have been given to do so.

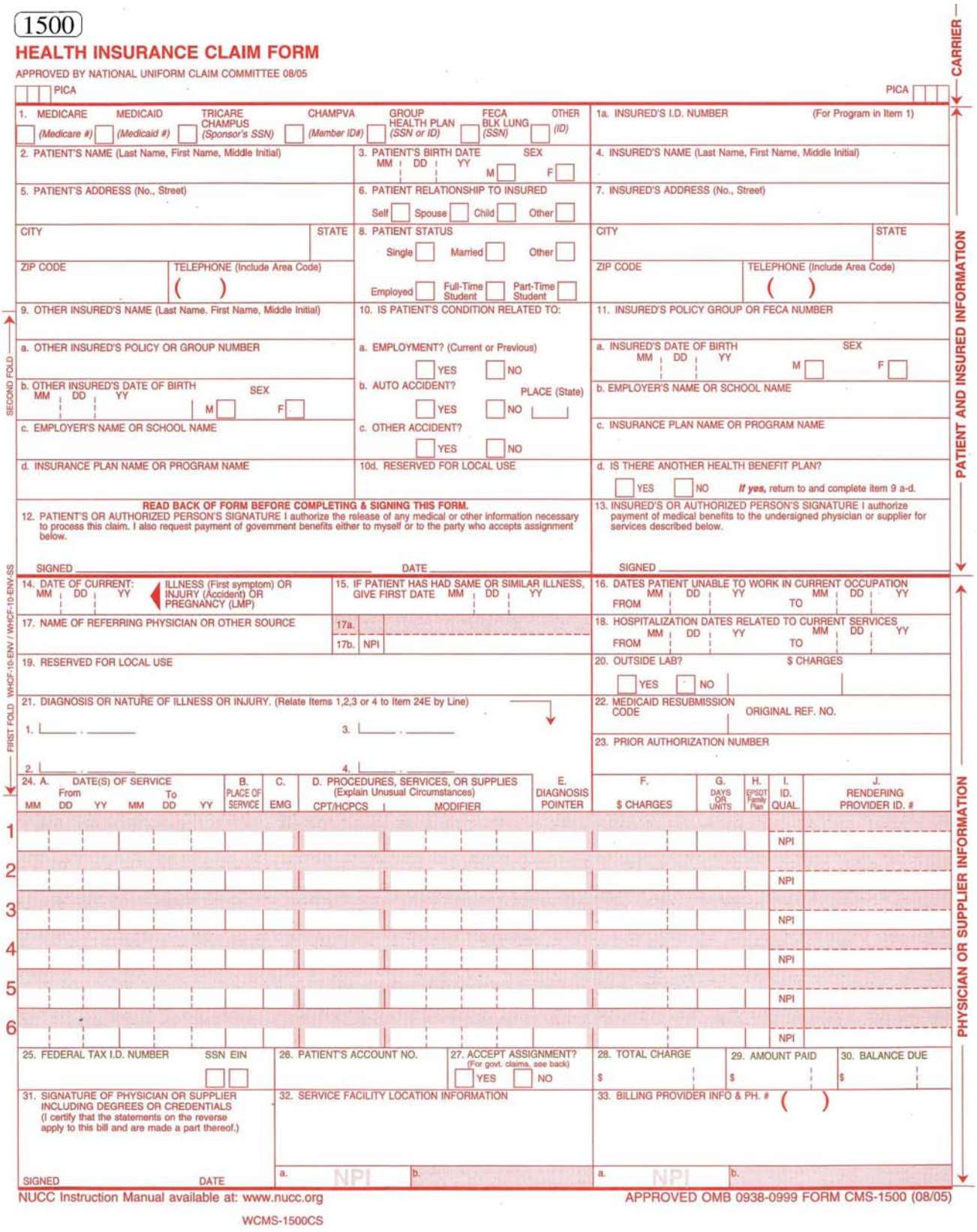
Field	Field Name	Use	Directions
1a	Patient ID	Required	Enter the participant's 7-digit Medicaid identification (MID) number exactly as it appears on the MAID card.
2	Patient's Name	Required	Enter the participant's name exactly as it appears on the MAID card. Be sure to enter the last name first, followed by the first name and middle initial.

Field	Field Name	Use	Directions
9a	Other Insured's Policy or Group Number	Required if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the policy number.
9b	Other Insured's Date of Birth/Sex	Required if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required if applicable	Required if field **11d** is marked yes.
9d	Insurance Plan Name or Program Name	Required if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Condition Related to Employment?	Required	Indicate Yes or No, if this condition is related to the participant's employment.
10b	Auto Accident?	Required	Indicate Yes or No, if this condition is related to an auto accident.
10c	Other Accident?	Required	Indicate Yes or No, if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check Yes or No, if there is another health benefit plan. If yes, return to and complete items **9a-9d**.
14	Date of Current: Illness, Injury or Pregnancy	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required if applicable	Use this field when billing for a consultation or Healthy Connections participant. Enter the referring physician's name.
17a	Other ID	Required if applicable	Use this field when billing for consultations or Healthy Connections participants. For consultations enter the qualifier **1D** followed by the referring physician's 9-digit Idaho Medicaid provider number. For Healthy Connections participants, enter the qualifier **1D** followed by the 9-digit Healthy Connections referral number. **Note**: The HC referral number is not required on Medicare crossover claims.
17b	NPI Number	Not Required	Enter the referring provider's 10-digit NPI number. **Note:** The NPI number, sent on paper claims, will not be used for claims processing.
19	Reserved for Local Use	Required if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the ICN of previous claims to establish timely filing.
21 (1-4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to four) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required	If applicable, enter the PA number from Medicaid, DHW, RMS, ACCESS, RMHA, QIO, or MT.

Field	Field Name	Use	Directions
24A	Date of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). **Example:** November 24, 2003 becomes 11242003 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.
24C	EMG	Required if applicable	If the services performed are related to an emergency, mark this field with an **X**.
24D 1	Procedure Code Number	Required	Enter the appropriate five character CPT or HCPCS procedure code to identify the service provided.
24D 2	Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as four. Otherwise, leave this section blank.
24E	Diagnosis Code	Required	Use the number of the subfield **(1-4)** for the diagnosis code entered in field **21**.
24F	Charges	Required	Enter the usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H	EPSDT (Health Check) Screen	Required if applicable	Not required unless applicable. If the services performed constitute an EPSDT Program screen, see *Section 1.6 EPSDT*, for more information.
24I	ID. Qualifier	Required if Legacy ID	Enter qualifier **1D** followed by the 9-digit Idaho Medicaid provider number in **24J**.
24J	Rendering Provider ID Number	Required if applicable	Enter the 9-digit Idaho Medicaid provider number in the shaded portion of this field if the **1D** qualifier was entered in **24I**. **Note:** If the billing provider number is a group, then paper claims require the 9-digit Idaho Medicaid provider number of the performing provider in the Rendering Provider ID Number field. **Note:** Taxonomy codes and NPI numbers, sent on paper claims, will not be used for claims processing.
28	Total Charge	Required	The total charge entered should be equal to all of the charges for each detail line.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance including Medicare. Attach documentation from an insurance company showing payment or denial to the claim.
30	Balance Due	Required	Balance due should be the difference between the total changes minus any amount entered in the amount paid field.
31	Signature and Date	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See *Section 1.1.4 Signature-on-File Form,* for more information.
33	Provider Name and Address	Required	Enter the name and address exactly as it appears on the provider enrollment acceptance letter or RA. **Note:** If you have had a change of address or ownership, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.
33A	NPI Number	Desired but not required	Enter the 10-digit NPI number of the billing provider. **Note:** NPI numbers, sent on paper claims are optional and will not be used for claims processing.

Field	Field Name	Use	Directions
33B	Other ID	Required	Enter the qualifier **1D** followed by the provider's 9- digit Idaho Medicaid provider number. **Note:** All paper claims will require the 9-digit Idaho Medicaid provider number for successful claims processing.

3.4.3.4 Sample Claim Form



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name. First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH. #

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS